Medical Assessments, Inc.

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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Home Health PT 12 (3x4) sessions

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is a Board Certified Orthopedic Surgeon with over 13 years of experience.

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female that tripped over X at work on XX/XX/XX and sustained a left open distal femur fracture.

XX/XX/XX: History and Physical. The claimant is a female that was injured at work when she tripped over X and landed on X. She really does not know what she tripped over. She was diagnosed with an open distal femur fracture on the left side. **X-Ray:** Distal femur fracture on the left side.

XX/XX/XX: Surgery consultation. **Diagnostic Studies:** Radiographs of the left knee demonstrates a fracture through the metaphysis of the distal femur with posterior displacement of the distal fragment without intercondylar extension. **Plan:** Patient will require left femur retrograde nailing with closed reduction and irrigation and debridement.

XX/XX/XX: Operative report. **Postoperative Diagnosis:** 1. Left supracondylar femur fracture, intra-articular 3 part. 2. Morbid obesity with BMI 41.8.

XX/XX/XX: Medication Administration Record

XX/XX/XX: PT. **Assessment:** Claimant exhibits a recent decline in strength, balance, functional activity tolerance and with gait and ADL's. Claimant would prefer to return to work. She would benefit from skilled PT services in order to address her barriers to safely return to her own home as well as to work when cleared by X. Claimant reported hurting. Patient requires homebound PT services due to decreased functional activity tolerance and safety with functional ambulation and mobility increasing PT's risk for falls. Claimant is currently residing with her

parents at their home due to her home being an upstairs apartment.

XX/XX/XX: PT. Claimant exhibited increased antalgic gait and decreased gait speed with SPC, however, she responded well to VCs from PT and did not exhibit LOB. Pain level 2/10.

XX/XX/XX: History and Physical. **Medications:** Aspirin, metformin oral, Ocuvite 150mg. Claimant reported she was ambulating with a cane into church on XX/XX/XX when her cane and shoe stuck to a mat on the ground and she fell onto her knees. She was seen in the ER later that evening and no new problems were found. She was placed in an immobilizer. **Plan:** Order X-ray- AP and lateral.

XX/XX/XX: PT. Claimant tolerated treatment W/O C/O increased L knee pain. Pain: 0/10.

XX/XX/XX: PT. Pain: 3/10. Claimant tolerated treatment well with reports of increased pain to 5/10 during treatment. Claimant was going to take pain pill after treatment.

XX/XX/XX: PT. Pain level: 2/10. Claimant tolerated treatment well with reports of increased pain to 6/10 during treatment. Claimant was going to take pain pill after treatment. Notified doctor of slowed progress since recent fall and claimant recommendations to delay return to work and continue PT services.

XX/XX/XX: PT Assessment. Claimant states her doctor recommended on her f/u that she delay her return to work x1 month for continued therapy at home due to her recent fall and set-back in rehabilitation of her injury. She states she has been trying to walk more, but she continues to have increased pain and difficult with L knee extension and weight bearing.

XX/XX/XX: UR. Rationale for denial: The claimant is a female with having a left femur fracture and underwent ORIF with IM rod placement to the left distal femur on X/XX/XX. The treatment plan included to continue PT to work on ROM, continued home exercise program, ice/elevate for pain and swelling and follow up. There was no documentation that the claimant required homebound PT services due to decreased functional activity tolerance and safety with functional ambulation and mobility increasing the claimant's risk for falls. However, there was no clear detail provided why the claimant's safety issues could not be addressed in an outpatient PT setting and there was no documentation of the claimant having other medical problems that would cause a homebound issue. There was also no documentation of any post-op complications occurring. Therefore, this request is non-certified.

XX/XX/XX: PT. Pain level 0/10. Claimant gait continues to normalize with increased weight shifting, heel strike and step length. Claimant is bearing approximately 15-20% of her weight L LE with gait this treatment session. Claimant weight shifting and ambulation tolerance are improving with PT intervention as well as her L knee ROM.

XX/XX/XX: PT. Claimant reported she has been stretching her L knee a bit since her last treatment session. She also stated she has already done her therapy today x1 set. Claimants gait continues to normalize with increased weight shifting, heel strike and step length.

XX/XX/XX: PT. Claimant reported she has been working on the step at her parents' home over the weekend some. She states her mom and dad have been working on cleaning up her apartment. Claimant tolerated treatment well without increased pain at the end of treatment session. Patient's weight shifting and ambulation tolerance continue to improve with PT intervention as well as her L knee ROM. L knee flexion has improved to 100deg. Patient is preparing to return to work and to her own home.

XX/XX/XX: UR. Rationale for denial: The claimant is a female involved in an X injury on XX/XX/XX. The claimant's doctor has recommended delay in return to work for one month for continued PT at home due to her recent fall and setback in her rehab on her injury. She states she has been trying to walk more but continued to have increased pain and difficulty with left knee extension and weight bearing limiting her safety and independence with ambulation and other functional mobility. At this time, the claimant is ambulating 150 feet and transferring

at a supervision/independent level. There is inconclusive evidence of any significant functional or medial barriers that would preclude the claimant from attending outpatient therapy. The request would not be medically necessary at this time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The request for home physical therapy is denied.

This patient sustained an open supracondylar femur fracture in X/XXXX. She is recovering from intramedullary nailing of her femur. She took another fall in X/XXXX, but sustained no further damage to her leg. The patient currently has 100 degrees of knee flexion. She has minimal knee pain with physical therapy.

There is no indication from the records reviewed that the patient is homebound. She is able to attend physical therapy at an outpatient facility.

Home physical therapy is not medically necessary for this patient.

ODG Guidelines:
Recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. (CMS, 2004)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**